

## Chapter 2

# Community Mental Health Centers at the 40-Year Mark: The Quest for Survival

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### Introduction

The community mental health movement is now 40 years old. Since created under the Kennedy administration, community mental health centers (CMHCs) have undergone a significant shift in treatment focus and sources of revenue. Their original mandate to provide comprehensive, community-based mental health services to all has given way to a focus on treating individuals with serious mental illnesses and substance use disorders. Centers no longer provide only mental health treatment services but have taken on a wide range of programs, such as housing and social supports, designed to allow people with the most serious disorders to live in their communities (Ray and Finley, 1994).

In the years since enactment of the Community Mental Health Centers Act of 1963, the movement has experienced a major change on the economic front. Broad Federal support has given way to survival of the fittest. The centers originally strove to achieve financial self-reliance through a broad payer mix; however, that goal never materialized, and centers turned to State funding once Federal support diminished. The present reality is that CMHCs increasingly rely on the Medicaid program for a significant portion of their revenues.

### Recent Influences

The original architects of this movement intended few, if any, of these changes. A number of factors have played a significant role in shaping the current environment in which CMHCs operate. Of particular concern over the past decade has been the proliferation of managed care programs in public-sector mental health systems and the general erosion of

health care resources devoted to mental health and addiction disorders (Kanapaux, 1999).

These two forces have combined to create an environment in which CMHCs must survive on the slimmest of financial margins and in many cases are forced to dip into cash reserves to meet the needs of the populations they serve. In a number of regions across the country, centers have been forced to consolidate with other centers or substantially to cut back on services, or both, to survive.

It is a case of health care rationing without rational dialog. Efforts to demonstrate the value of community-based services in a meaningful and systematic way have failed to materialize over the past 10 years, and the community mental health system remains at risk of being reduced to a commodity as both public and private health care systems grapple with the ongoing problem of rising health care costs.

The current situation suggests a policy failure at local, State, and Federal levels. Despite a resounding message over the past 10 years that treatment works, little effort has been made to ensure that community-based services receive the support they need. Consequently, a majority of CMHCs find themselves in the difficult position of fulfilling their service mission while having to make tough business decisions to survive financially.

*Mental Health: A Report of the Surgeon General*, released in late 1999, made front-page headlines across the country and appeared to signal a new priority at the health policy level to make effective mental health treatments available to anyone in need (Healy and Marquis, 1999; Kaufman, 1999; Pear, 1999). Likewise, the move toward parity insurance coverage for mental illnesses offered the promise of an end to the disproportionate erosion of behavioral health resources in relation to overall health care spending. However, the mental health

parity law passed by Congress in 1996 and implemented in 1998 offered limited scope, prohibiting only lifetime and annual limits. It did not address per-episode limits on length of stay or outpatient visits, nor did it eliminate discriminatory copayments. Efforts to expand the parity law to address these loopholes have met with resistance from large employers. In 2002, legislation was proposed in the Senate, but the House did not take action.

State budget problems also threaten to erode Medicaid programs. The Nation's governors are pushing for greater flexibility that would bring fewer Medicaid benefits to more people. Optional mental health services in particular are at risk as governors seek ways to get the most out of their Medicaid dollars. Even in the flush times of the 1990s, when many State budgets generated surpluses, overall funding for mental health services did not increase appreciably.

However, there is cause for optimism. After nearly a decade of striving to develop a common set of outcome measures to demonstrate the value of mental health services, a new emphasis has been placed on establishing evidence-based treatment protocols. The reasoning behind this trend is that if certain treatment protocols are proven to produce good outcomes, their replication will produce good outcomes as well. The establishment of an evidence base for community-based programs would help establish in the minds of policymakers that CMHCs offer valuable services that improve individual lives and strengthen the community.

Another possibility for CMHCs to regain lost status can be found in the growing consensus that integrated mental and physical health care produces better outcomes than does nonintegrated care. However, this too presents many challenges to CMHCs. One major area of concern is a recent emphasis by the Federal government on bringing integrated care to federally funded community health centers. Community health centers also were established in the mid-1960s. However, unlike their counterparts in mental health, they have always received full Federal support. Lack of Federal funding to CMHCs to support integration efforts creates an imbalance and raises the possibility that the public mental health sector will fall behind in the push for innovative treatment approaches.

## **The Beginning of a Movement**

To fully understand the state of CMHCs today, one must first look at their origins. From the enact-

ment of the Community Mental Health Centers Act of 1963 to the 1981 repeal of its amended version, CMHCs developed with full Federal support.

In the beginning, recipients of construction grants were required to provide a comprehensive program of five essential services—inpatient, outpatient, partial hospitalization, 24-hour crisis, and consultation and education—to all residents of designated service areas (catchment areas). For a 20-year span, these centers were to serve individuals regardless of age, race, religion, place of national origin, or diagnostic classification.

The original intent was for the centers to receive 4½ years of funding for initial staffing purposes, allowing them time to develop alternate funding sources to become self-sufficient. Federally funded CMHCs were required to provide a “reasonable volume” of free or reduced-cost care, but early planners believed that other revenue sources would bear the operating costs: fee-for-service patients; individual and group insurance; other third-party payments; voluntary and private contributions; and State and local aid. The Federal expectation was that this new and expensive undertaking for most communities would require only temporary Federal aid (Brown and Cain, 1964). However, several serious flaws in expectations and design kept this from happening.

One of the most serious and dangerous flaws in the original design was the expectation that CMHCs would serve a substantial number of patients who would be able to pay for their own treatment. Clearly, the intent of Congress and President Kennedy was that CMHCs would make the transition to self-sufficiency following their initial funding cycle. This expectation, however, ran counter to the consequences of downsizing State psychiatric hospitals, which began in earnest during the 1960s. CMHCs were expected to treat patients who often arrived at the centers with no ability to pay. Meanwhile, patients from third-party payers, such as employee health plans, failed to materialize. Considering the high level of stigma associated with mental health treatment during those formative years, it is no wonder that consumers with private insurance would hesitate to seek treatment from a center along with consumers who were newly released from State mental hospitals.

The CMHC program also was expected to bring mental health treatment into the mainstream of other health care services. General and community hospitals were encouraged to apply for the Federal funds (Sharfstein, 1978). Those who framed the CMHC Act believed that the colocation of mental health centers in general health facilities would

encourage a realignment of care and allow coordination among other physicians and psychiatrists. However, this did not become a widespread practice; the debate over integration and colocation of care continues to this day.

As it became clear that CMHCs were not achieving self-sufficiency, policymakers debated the fate of the program. In 1976, Congress amended the original Act in an attempt to stabilize and expand the program. The new Act increased the number of required core services from 5 to 12 and added compliance features designed to promote accessibility of services. It also added requirements regarding quality assurance, cultural sensitivity, and expansion of governance to represent a cross-section of the catchment area. Further, it instituted multiple reporting requirements that significantly increased administrative burden.

However, funding continued to lag behind construction grant applications. By 1978, it appeared unlikely that the CMHC program would ever reach the intensity and comprehensiveness set forth in the original legislation.

More than 800 unfunded catchment areas remained. Of the 675 fully funded CMHCs, 60 no longer received any Federal support, while 329 still received staffing grants. Many CMHCs that were unaffiliated with community hospitals experienced severe difficulty in receiving reimbursement for services. As a result, CMHCs began shifting from clinical/medical programs to social programs (Sharfstein, 1978).

Even though the CMHC Act was enacted prior to the creation of Medicare and Medicaid in 1965, CMHCs were not certified Medicare providers and were excluded in many States from participating in the Medicaid program. That began to change in 1981, following the repeal of the Mental Health Systems Act (Ray and Finley, 1994). That law, which Congress had passed only 1 year earlier, sought to restructure and realign the Nation's mental health system.

## **An Era of Transformation**

The 1981 repeal of the Mental Health Systems Act brought significant structural and financial changes to community mental health services. Federal funding available to CMHCs in 1982 through the newly established Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant dropped nearly 30 percent from the previous year's

funding. This decrease resulted in dramatic service reductions.

CMHCs never recovered the funding and experienced further erosion of block grant money as program appropriations continued to lag behind inflation as measured by the consumer price index. By 1993, the block grant program represented, on average, only nine percent of CMHC revenue (National Community Mental Healthcare Council [NCMHC], 1994).

The degree of distress that CMHCs experienced as a result of the funding reductions during the 1980s depended in large part on how reliant they had been on Federal funding, and on each State's willingness to support community mental health services by replacing those lost funds. In general, CMHCs responded by maintaining direct services and reducing services to populations without a designated funding source. Services such as consultation, education, prevention, and research were substantially reduced or eliminated (Larson, 1986).

The shift in funding sources that occurred during the 1980s illustrates the extent of the change. At the height of the CMHC movement in 1975, the average agency's budget came from the following revenue sources: 30 percent Federal, 29 percent State, 10 percent Medicaid, nine percent local government, two percent Medicare, and four percent patient fees. The remaining eight percent came from other sources (Sharfstein and Wolfe, 1978).

By 1985, Federal funds through the ADMS block grant had dropped to 11 percent of agency budgets. State funding grew substantially to 42 percent and local government sources increased to 13 percent. Medicaid fell slightly to eight percent, Medicare remained at two percent, and patient fees grew to eight percent. Revenues from private insurance, which had been inconsequential in 1975, rose to seven percent.

Meanwhile, the Federal government became more proactive in encouraging community care through the expansion of allowable uses of Federal funds in community programs. This began with passage of the State Mental Health Planning Act of 1986, which authorized small grants to States to develop comprehensive mental health plans for persons with serious mental illness. It also restored a small Federal leadership role in attempting to coordinate State services to individuals in the community who have serious mental illness. The Act increased stakeholder input into plans for expansion of community services and ensured a more rational allocation of resources for services to individuals with serious mental illness.

Also in 1986, Congress enacted a steady stream of amendments to Medicare and Medicaid that made these two critical programs more accessible to community-based providers. The first of these changes established case management as a distinct benefit under Medicaid, an option that many community mental health programs used extensively to expand the delivery of case management services. Other Medicaid amendments expanded clinic services to persons with serious mental illness who were homeless; clarified coverage for rehabilitative services; and prohibited the use of nursing homes as a site for transinstitutionalization of persons with serious mental illness who were released from State mental hospitals without community placement.

These changes played a significant role in changing the CMHC revenue mix. Centers now had easy access to Medicaid funding for the services they offered. As a result, reliance on this revenue source increased dramatically.

Congress also amended Medicare. In 1987, Medicare increased outpatient mental health benefits for the first time since the program's enactment in 1965. Subsequent amendments were expected to make it easier for nonmedical personnel employed at CMHCs to bill the program for services. The key change came in 1991, when the Health Care Financing Administration (HCFA) granted CMHCs direct provider status for partial-hospitalization services. In subsequent years, however, CMHCs encountered significant reimbursement problems related to the partial-hospitalization program, and its potential was never fully realized.

## The 1990s

By 1990, CMHCs served an average of 2,807 persons annually. Of the total clients seen, 46 percent had a primary diagnosis of serious mental illness; another six percent had a primary diagnosis of substance abuse with mental illness. These populations required extensive resources and services and contributed to the shift in focus at CMHCs to the most severely ill within the total client population. Many CMHCs provided a number of specialty programs: 62 percent had programs for children and adolescents; 43 percent had programs for alcohol abusers; 39 percent had programs for drug abusers; 37 percent had programs serving families of persons with serious mental illness; and 22 percent had programs for homeless persons.

Double-digit inflation in medical costs caused the private and public health care systems to consider ways to control expenses. Managed care plans were proliferating on the physical health side and began to gain a foothold in mental health as well. Private health plans embraced the carve-out model for managing mental health and addiction treatment, and public mental health systems followed suit with efforts to control Medicaid and State expenditures.

CMHCs, which already faced daunting financial challenges, faced even greater competition for resources. In some States, public officials openly acknowledged that only the strongest CMHCs would survive and that vulnerable centers should consider consolidating with other providers. Because most centers relied heavily on State revenues, they were largely at the mercy of State-level policy decisions.

An extensive network of community mental health providers had developed since the inception of the CMHC movement 30 years earlier, but large service gaps continued to exist for both adults and children. The dream of a comprehensive service delivery system designed to be self-sustaining and to meet all mental health needs within a catchment area dissolved for good in the 1990s. In its place, CMHCs struggled to provide services for persons with serious mental illness despite a significant lack of resources.

Deinstitutionalization brought with it many unintended consequences, including the fragmentation of services. In the early stages of downsizing State psychiatric hospitals, it became clear that issues concerning responsibility for both costs and services to this population were far from settled (General Accounting Office [GAO], 1977). Public-sector managed mental health care systems were intended to address that issue, but cost concerns more frequently than not overrode any well-intentioned designs to reinvest savings in further development of community services.

CMHCs and other community-based providers suffered financially. In many States and localities, lack of a cohesive public health policy threatened the very safety net on which people with serious mental illness depended. Those who fell through the treatment gaps wound up in a revolving-door cycle that led from acute hospitalization to homelessness to arrest. In many parts of the country, jails and prisons became de facto psychiatric institutions. Services that could have kept these clients in the community, namely, affordable housing and other social supports, were hard to come by. These problems persist into the 21st century.

## **Public Sector Managed Care**

In the mid-1990s, many stakeholders viewed public-sector behavioral health carve-outs as the solution. Managed care entities would be able to develop greater efficiencies in public systems, using their technological infrastructure to streamline administrative processes, such as claims payment, utilization review, and quality assurance. Although the managed care contractor would take its cut of administrative costs and profits, these amounts would be limited by contract. Additional savings would be reinvested in community-based services, allowing States and localities to develop a cost-effective system that provided the right mix of services to those in need.

Yet, these goals were rarely, if ever, realized. Managed care contractors ran head-on into the reality that most if not all public-sector systems had suffered years of chronic underfunding. In their rush to beat the competition to large contracts, many managed care companies grossly underestimated the true costs of running these public-sector programs.

The second half of the 1990s brought some high-profile failures in public-sector systems (Kanapaux,

themselves. In other areas, the centers have partnered with managed care companies to develop a system that functions effectively within budgetary constraints.

The successes, however, were the exception rather than the rule. The knowledge gained from these programs largely evaporated as private managed behavioral health care companies shied away from taking on new public-sector programs. The profit margins were slim to nonexistent, and purchasers continued to become more sophisticated in stipulating what they wanted for the money. The days of low bids and winning contracts at any price were over. By the end of 1999, fewer private companies were pursuing new contracts.

## Working With Medicare

Beginning in 1991, HCFA expanded the partial-hospitalization benefit under Medicare to include participation by CMHCs. Community providers greeted the change with enthusiasm. It signaled a chance to draw on an additional revenue stream while providing services that were critical for helping keep people who were disabled enough by their mental illness to qualify for Medicare out of hospitals.

However, within several years, it became apparent that HCFA's implementation of the expanded benefit was significantly flawed. The partial-hospitalization benefit proved to have significant loopholes that allowed disreputable providers posing as CMHCs to bilk the program.

An investigative report released by the General Accounting Office (GAO) in 2000 found that HCFA did not adequately assess the qualifications of participating providers (GAO, 2000). This resulted in the inclusion of so-called CMHCs that were intent on committing fraud. Payments to CMHCs for the partial-hospitalization benefit grew from \$60 million in 1993 to \$349 million in 1997, with payments per patient increasing from \$1,642 to \$10,352 during that period. More than 90 percent of Federal payments made for partial-hospitalization services in five States were found to be inappropriate.

The fraud, once exposed, tarnished the reputation of CMHCs. But an inconsistent application of Federal payment rules for the benefit proved to be even more damaging to legitimate providers. The GAO found that HCFA failed to give its payment contractors detailed instructions on how to review claims and detect billing problems. This lack of

guidance resulted in a patchwork of standards around the country. In numerous cases, Medicare's fiscal intermediaries imposed rule changes without advance notice and in some cases applied those rules retroactively.

En masse, CMHCs dropped the partial-hospitalization benefit from their menu of services. Sweeping audits, denial of claims, and demands that centers repay previously approved claims made the benefit far too costly for providers. And a chance to strengthen the community system fell by the wayside.

## Prognosis for the New Century

After an early recession, the 1990s proved to be economic boom times. The stock market grew at a dizzying pace. Tax revenues surged. State budgets ran surpluses. Nonetheless, the 1990s were tough times for most CMHCs and for community mental health systems in general. With that in mind, it is difficult to see how the new century can bring anything but more financial challenges to CMHCs.

Medicaid payments now account for the lion's share of CMHC revenue, often approaching 80 percent or more. As mentioned earlier, this reliance on State-driven funding is a direct result of the Federal decision to abandon full support for CMHCs. And it makes centers especially vulnerable at a time when the Nation's governors are sounding the alarms about deficit budgets and the impact they will have on Medicaid programs.

In 2002, the National Governors Association questioned Medicaid's future viability and asked the Federal government to pick up a larger share of the burden for providing services to the elderly and disabled. The governors also are seeking greater flexibility in Medicaid programs so they can cover more people with fewer benefits. As the number of uninsured people continues to grow, the push for flexibility likely will grow as well.

If the governors' campaign is successful, the result will be a weakening of financial support for community-based mental health systems. This could not come at a worse time. Freestanding psychiatric hospitals and general hospital psychiatric units endured their own financial challenges in the 1990s, and beds are at a premium. Already, shortages in these systems have resulted in emergency rooms at general hospitals being overrun with people in psychiatric crisis. Many of these crises could be avoided altogether with the right mix of community supports, and

that was clearly the intent when States began emptying their mental hospitals.

Reality, however, has fallen far behind. The Department of Justice (DOJ) has concluded that persons with serious mental illness are overrepresented in the Nation's criminal justice system. In 1998, more than a quarter million people with mental illness were housed in the Nation's jails and prisons. Another half million were on probation in the community. State prisoners with mental illness served sentences that were 17 percent longer than those of other inmates. The majority of these prisoners are nonviolent, low-level offenders (DOJ, 1999).

For those whom the system has failed completely, the time between hospitalization and arrest is often marked by homelessness. Of the Nation's homeless, 39 percent report some form of mental health problems and up to 25 percent meet the criteria for serious mental illness (National Resource Center on Homelessness and Mental Illness [NRCHMI], 2002). CMHCs and other community-based providers have recognized this problem for years and have attempted to address it with supportive housing and other services, but funding for these types of programs is difficult to come by.

Another important aspect of community systems that has been affected by this lack of funding is human capital. The financial pressure on CMHCs has resulted in salaries that frequently are less than competitive. Low salaries coupled with staff reductions that have increased workloads have caused worker morale to suffer, and employee turnover is often the result. Finding qualified staff becomes a far greater challenge in this environment.

## **A Glimmer of Hope**

As dire as these problems are, the situation is reversible. An effective community-based system requires careful deliberation by local, State, and Federal officials to devise effective policies and to find the resources to support them. One area of promise is the recent emphasis on evidence-based treatment guidelines. Treatment protocols and supports that have been scientifically proven to produce desired outcomes can take a lot of the guesswork out of policy and funding decisions. There are, however, some challenges to making evidence-based guidelines a reality.

Fidelity to guidelines for evidence-based treatment practices is critical to their success. And the biggest challenge to that is finding a way to ensure

that clinical staff adopt and implement those practices on a systemwide basis. New York State began moving toward such an effort in 2001, and other public systems are planning to follow in the years ahead.

Another challenge is that the science base for certain treatments and programs is marginal at best. Without sufficient research and data, these programs run the risk of being neglected by systems with limited resources. The Federal Government can play a key role in this regard by providing research funding to build an evidence base for community supports and systems that currently are supported by little more than anecdote.

Another area of promise can be found in the growing consensus that primary care and behavioral health services need to be better integrated (Department of Health and Human Services [HHS], 2000). A growing body of evidence showing the effectiveness of integrated care should serve as a wake-up call for policymakers as they struggle with ways to control health care costs in the public sector.

This is another area in which the withdrawal of Federal support has hurt CMHCs. Community health centers, which have continued to enjoy full Federal support since their creation in the mid-1960s, are eligible for \$100,000 per year grants from the Health Resources and Services Administration (HRSA) to provide integrated care, primarily through the colocation of a behavioral health specialist in their health care clinics. HRSA earmarked \$40 million in 2002 to fund this initiative.

No such support exists on the behavioral health side, despite the fact that CMHCs play a critical role in providing support services to roughly the same populations as those served by the community health centers. Further, without integrated services, many people with serious mental illness do not receive adequate care for co-occurring physical health problems. CMHC participation in integrated care is essential for systems hoping to provide the most effective care with finite resources.

CMHCs overall have shown remarkable resilience in their 40-year history. Emerging from a program hampered by flawed expectations and design, they have grown to become an essential piece of the health care system, often offering the last chance for care for some of the Nation's most vulnerable populations. This has been achieved through sheer willpower, commitment, and vision. But those resources are finite as well.

Health care rationing is a reality. It can happen as a deliberate, thoughtful strategy or it can be dic-

tated by the vagaries of market forces and the economy's changing climate. The CMHCs' original mandate to provide comprehensive, community-based mental health services is more critical now than ever. Yet many of these centers find themselves on the precipice of extinction.

Their fate lies in the hands of Federal and State policymakers. So does the well-being of millions of Americans who rely on the safety net that CMHCs provide.

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